MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2349 — Reg. Dist. No. 0233

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FUNKSTOWN
d. STREET ADDRESS: 24 E. GREEN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AUDREY — Middle MAXINE — Last ANGLE

4. DATE OF DEATH: Month 2 — Day 10 — Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 17, 1911
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSPECTOR
10b. KIND OF BUSINESS OR INDUSTRY: AIRCRAFT
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: IRA T. ANGLE SR.
14. MOTHER'S MAIDEN NAME: SALLY BANKARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-16-3870
17. INFORMANT: MRS. RAY HENNINGER — Address: FUNKSTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Ovary with
175.0
DUE TO
(b): Metastasis to Liver, Adrenal + Lungs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sept 18-1958

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 18, 1958 to July 10, 1959 that I last saw the deceased alive on July 10, 1959, and that death occurred at 6:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sidney Rovenstein M.D. — ADDRESS (Street, city or town, state): Funkstown Md — DATE SIGNED: 7/11/59

PHYSICIAN'S NAME (Type): SIDNEY ROVENSTEIN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7/12/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: FRED W. KRAISS HAGERSTOWN, MD.
24a. REC'D BY REGISTRAR — DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraiss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [illegible] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02340

CERTIFICATE OF DEATH

2350 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1 223 Norway Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle F — Last Athey
4. DATE OF DEATH: Month 2 — Day 26 — Year 19 59
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-12-1909
9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: W. Md. R. R.
11. BIRTHPLACE (State or foreign country): Parsons, W. Va.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Thomas M. Athey
14. MOTHER'S MAIDEN NAME: Ida Mae Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-10-7432
17. INFORMANT: Mrs. Anna J. Athey — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 151X
DUE TO (b): Carcinoma Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO (c): Generd. Metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-1-58, 19____, to 2-26, 19 59, that I last saw the deceased alive on 2-25-59, 19____, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: Fred W. Kraiss — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 2-27-59
PHYSICIAN'S NAME (Type): Fred W. Kraiss — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3-1-59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven
22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2351 (Reg. Dist. No.) 12341

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Smithsburg
d. STREET ADDRESS: Smithsburg #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Earl	Roy	Bachtell	Feb.	14	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Male	White	WIDOWED [X]	3/22/1884	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired, Farmer		Near Smithsburg	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David H. Bachtell	Selena Barkdoll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	215-36-5947A.	David E. Bachtell, Smithsburg Md., Route 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	2 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Generalized Arteriosderosis	4 yrs.
DUE TO (c)		

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work / Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
o. m. / p. m. 19			

21. I certify that I attended the deceased from 2-12, 1959, to 2-14, 1959, that I last saw the deceased alive on 2-14, 1959, and that death occurred at 11:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess, M.D. — ADDRESS (Street, city or town, state): Smithsburg Md. — DATE SIGNED: 2-15-59

PHYSICIAN'S NAME (Type): Charles F. Hess

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/17/59	Smithsburg	Smithsburg, Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Walter Y. Grove, Waynesboro Pa.	FEB 18 '59	Arthur L. Rivers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2,10,13,14 Film 0239 3-2-59 et

CERTIFICATE OF DEATH

2352

Reg. Dist. No. 0242

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Funkstown
d. STREET ADDRESS: King Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Agnes — Last: Barnes

4. DATE OF DEATH: Month: Feb — Day: 20 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 7, 1891

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bedford Co Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Dennis Barnes

14. MOTHER'S MAIDEN NAME: Lavine Cavendar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dennis Jay [redacted] Address: Clearville, R.D.1 Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

175.0

DUE TO (b): Carcinoma of Ovary — 8 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 15, 1950, to Feb 20, 1959, that I last saw the deceased alive on Feb 20, 1959, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John A. Moran M.D. ADDRESS (Street, city or town, state): 215 W. Washington St DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): JOHN A. MORAN MD

22a. BURIAL, CREMATION, REMOVAL (Specify):

22b. DATE THEREOF: 2/23/59

22c. NAME OF CEMETERY OR CREMATORY: Fairview

22d. LOCATION (City, town, or county) (State): Bedford Co. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Lynford Conner ADDRESS: Everett Pa

24a. REC'D BY REGISTRAR DATE: FEB 24 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2353 — Reg. Dist. No. 02343

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 1269 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle ALBERT — Last BECK
4. DATE OF DEATH: Month FEBRUARY — Day 13 — Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/3/1891
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY: CITY WATER PLANT
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. FRANK BECK
14. MOTHER'S MAIDEN NAME: BLANCHE HARTLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): W.W.#1
16. SOCIAL SECURITY NO.: 214-09-2250
17. INFORMANT: MRS. MABLE D. BECK — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Squamous cell Carcinoma tongue
141.9
DUE TO
(b): with metastasis to neck
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Cervical region
INTERVAL BETWEEN ONSET AND DEATH: 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign prostatic hypertrophy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 30, 1958 to Feb 13, 1959, that I last saw the deceased alive on Feb 12, 1959, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto III M.D. — ADDRESS (Street, city or town, state): 217 W. Washington St. — DATE SIGNED: 2-14-59

PHYSICIAN'S NAME (Type): Edward W. Ditto 111 M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/15/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. I. Norment, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Clarence L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2354

CERTIFICATE OF DEATH

02344
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 65 YRS.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 6 W. IRVIN AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAMLIE — Middle ELIZABETH — Last BENTZ

4. DATE OF DEATH: Month FEBRUARY — Day 3 — Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/5/1868

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM D. SPIKER

14. MOTHER'S MAIDEN NAME: MARTHA VIRGINIA MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MRS. PAULINE MEREDITH — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO (b): Arteriosclerosis — 7 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardiovascular Dis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 July 19 51 to 3 Feb 19 59 that I last saw the deceased alive on 3 Feb 19 59, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D.
ADDRESS (Street, city or town, state): 1135 POTOMAC AVENUE
DATE SIGNED: 4 FEBRUARY 59

PHYSICIAN'S NAME (Type): RICHARD T. BINFORD, M. D. — HAGERSTOWN, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/7/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Mermet — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: FEB 9 '59
24b. REGISTRAR'S SIGNATURE: C. I. S. Hiaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2355 **CERTIFICATE OF DEATH** Reg. Dist. No. 02345

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 34 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 8 Wabash Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Henry — Last: Blair Sr.

4. DATE OF DEATH: Month: February — Day: 3 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 16, 1910

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard

10b. KIND OF BUSINESS OR INDUSTRY: Aircraft

11. BIRTHPLACE (State or foreign country): Clearspring Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Percy Blair

14. MOTHER'S MAIDEN NAME: Nora Hull

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown): ---
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-5051

17. INFORMANT: Mrs. Mary E. Blair — Address: Hagerstown md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Occlusion of right Common Iliac — INTERVAL BETWEEN ONSET AND DEATH:
446 X
DUE TO: Artery with Gangrene peri - thigh - ; 3-4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ~~lead to the pulmonary embolism~~
DUE TO
(c) Nephrosclerosis - advanced - Diabetes mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1956, to Feb 3, 1959, that I last saw the deceased alive on Feb 2, 1959, and that death occurred at 8:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto M.D. — ADDRESS (Street, city or town, state): 217 W. Washington St. Hagerstown, Maryland — DATE SIGNED: 2-4-59

NAME (Type): Edward W. Ditto III

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-6-59
22c. NAME OF CEMETERY OR CREMATORY: St. Pauls Cemetery
22d. LOCATION (City, town, or county) (State): Near Clearspring Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: FEB 9 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2417 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 125 East Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle CATHERINE Last BLOOM

4. DATE OF DEATH: Month February Day 3 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 4, 1869
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christian Heckman
14. MOTHER'S MAIDEN NAME: Frederika Dunnel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Ray Heckman — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Diffuse Atherosclerosis — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
400.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-1, 1959 to 2-3, 1959, that I last saw the deceased alive on 2-3, 1959, and that death occurred at 6:55 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M Bryhat M.D. — ADDRESS (Street, city or town, state): 284 W Potomac — DATE SIGNED: 2-5-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/6/1959
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — N. Franklin Rouzer — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE FEB 6 '59
24b. REGISTRAR'S SIGNATURE: C. H. S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2418

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Middleburg
c. LENGTH OF STAY IN 1b: 3 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Penna. b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Greencastle
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Charles Middle Walter Last Bonebrake
4. DATE OF DEATH: Month Feb. Day 24, Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 27, 1906
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): engineer
10b. KIND OF BUSINESS OR INDUSTRY: railroad
11. BIRTHPLACE (State or foreign country): Franklin Co., Penna.
12 CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jacob Bonebrake
14. MOTHER'S MAIDEN NAME: Lucy Hahn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 705-10-6769
17. INFORMANT: Reba M. Bonebrake, Greencastle, Pa. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: indefinitely
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/[illegible], 19____, to 2/21/59, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 136 N. Potomac St. DATE SIGNED: 2/25/59
PHYSICIAN'S NAME (Type): Howard V. Weeks, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2-27-59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 2 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ■ hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02348

CERTIFICATE OF DEATH

2356 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 728 Frederick St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY — Middle LESUSTER — Last BOWARD

4. DATE OF DEATH: Month Feb. — Day 6 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan.6,1888
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W. Boward
14. MOTHER'S MAIDEN NAME: Helen Cline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 214-09-2933
17. INFORMANT: Harry L. Boward — Address: 728 Frederick St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 1 d

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary Thrombosis — 1 d

DUE TO

(c) Diabetes — 10 yrs

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Nephrosclerosis Ascites

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-3, 19 59 to 2-6, 19 59, that I last saw the deceased alive on 2-6, 19 59, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J R Duryea M.D. — ADDRESS (Street, city or town, state): 245 N Potomac — DATE SIGNED: 2-8-59

PHYSICIAN'S NAME (Type): J R Duryea — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/9/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S

Wm. A. Horst U-Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02349

2419 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 78 yrs.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 132½ S. Vermont Street
d STREET ADDRESS: 132½ S. Vermont St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Daisy — Middle: Alice — Last: Bowers

4. DATE OF DEATH: Month: Feb. — Day: 10 — Year: 19 59

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 11 1880
9 AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months 6 — Days 29
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Andrew Blair
14. MOTHER'S MAIDEN NAME: Amanda Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Nellie Rancourt — Address: 238 N. Lucerne St. Baltimore, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-6-59 to 2-10-59 that I last saw the deceased alive on 2-10-59, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Young M.D — ADDRESS (Street, city or town, state): William Street Hagerstown Md — DATE SIGNED: 4/11/59

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 13-59
22c NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leigh — ADDRESS: Williamsport, Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 59
24b REGISTRAR'S SIGNATURE: Ann L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2357

CERTIFICATE OF DEATH

02350
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md
c. LENGTH OF STAY IN 1b: 3 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hancock Rural 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Deborah — Last: Breen

4. DATE OF DEATH: Month: 2 — Day: 15 — Year: 19 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12.1868

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months 9 Days 3 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Worked

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington County Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Breen

14. MOTHER'S MAIDEN NAME: Catherine Dillon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: Mary M Mills Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arterio Sclerotic Heart Dis' — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

4 ow.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 53, to Feb. 15, 1959, that I last saw the deceased alive on Feb. 13, 1959, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring Md. — DATE SIGNED: 2/17/59

PHYSICIAN'S NAME (Type): David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2.18.59

22c. NAME OF CEMETERY OR CREMATORY: St. Peters Catholic

22d. LOCATION (City, town, or county) (State): Hancock Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Howard F Stone Hancock md

24a. REC'D BY REGISTRAR — DATE: FEB 24 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 11, 0239 3-9-59 et

2358

CERTIFICATE OF DEATH

Reg. Dist. No. 0235

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN, MARYLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION: WESTERN MD STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON, MARYLAND
d. STREET ADDRESS: 10713 SHAFTSBURY ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fannie — Middle: LEE — Last: BROWN

4. DATE OF DEATH: Month: Feb. — Day: 25 — Year: 1958-19 59

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/6/1868 1906

9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WINTERGREEN, VIRGINIA

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: MARSHALL STEWART

14. MOTHER'S MAIDEN NAME: ELIZA TURNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: STANLEY LOVE — Address: KENSINGTON, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Empyema — INTERVAL BETWEEN ONSET AND DEATH: 5 days

576X

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO (b): liver abscess — 4 mos.

DUE TO (c): sub diaphragmatic abscess — 6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): carcinoma of head of pancreas

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 5, 1958, to Feb. 25, 1958, that I last saw the deceased alive on Feb. 25, 1958, and that death occurred at 9:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L. Ramos, M.D. — ADDRESS (Street, city or town, state): western md. state hospital — DATE SIGNED:

PHYSICIAN'S NAME (Type): Victor L. Ramos — Hagerstown, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/28/59

22c. NAME OF CEMETERY OR CREMATORY: GLEN MARY CEMETERY

22d. LOCATION (City, town, or county) (State): WINTER GREEN VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Hawkins — ADDRESS: Rockville Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '59

24b. REGISTRAR'S SIGNATURE: Chas E Keech

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2359 CERTIFICATE OF DEATH

Reg. Dist. No. 1125

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County DOA Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 819 Washington Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS — Middle AUGUSTA — Last BRUMBAUGH
4. DATE OF DEATH: Month FEBRUARY — Day 6 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 13 JUNE 1895
9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BAKER
10b. KIND OF BUSINESS OR INDUSTRY: BREAD
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY: U.S.A
13. FATHER'S NAME: John Brumbaugh
14. MOTHER'S MAIDEN NAME: NANNIE SECKMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 234-01-8247
17. INFORMANT: MRS. MARIE BRUMBAUGH — Address: 819 Washington Ave HAGERSTOWN, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immed

DUE TO (b): general arteriosclerosis and

DUE TO (c): arteriosclerotic heart disease — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/4, 1959, to 2/6/59, 19____, that I last saw the deceased alive on 2/4, 19 59, and that death occurred at 12:30 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Edward W. Ditto M.D. — ADDRESS (Street, city or town, state): 217 W. Washington St. — DATE SIGNED: 2-9-59

PHYSICIAN'S NAME (Type): Edward W. Ditto III M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9 FEB. 1959
22c. NAME OF CEMETERY OR CREMATORY: ROSEDALE
22d. LOCATION (City, town, or county) (State): MARTINSBURG, W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 11 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2360

CERTIFICATE OF DEATH

02353

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN, MD.
c. LENGTH OF STAY IN 1b FEW HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHI...
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CLEAR SPRING, MD. ROUTE 1
d. STREET ADDRESS NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JANNETTE Middle DORTHY Last BURKETT
4. DATE OF DEATH Month FE... Day 15 Year 19..

5. SEX F
6. COLOR OR RACE WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 3, 1926
9. AGE (In years last birthday) 32 yrs.
IF UNDER 1 YEAR Months 11 Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) CLEAR SPRING, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME EDWARD DANIEL KING
14. MOTHER'S MAIDEN NAME ELLA ...

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ...-...
17. INFORMANT Address ...

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Hours/Minutes
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19..
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from 2/15/59 19.. to 2/15/59 19.., that I last saw the deceased alive on 2/15/59 19.., and that death occurred at 9:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Ralph E. Young M.D
ADDRESS (Street, city or town, state) Williamsport
DATE SIGNED 2/15/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF Feb 17, 19..
22c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S ...
22d LOCATION (City, town, or county) (State) ST. PAUL'S, MD.

23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS CLEAR SPRING, MD.
24a. REC'D BY REGISTRAR DATE FEB 18 '59
24b REGISTRAR'S SIGNATURE Thos S. Kinsella

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02354

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 17 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1004 HAMILTON BLVD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1126 HAMILTON BLVD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle CLYDE — Last BURKHOLDER
4. DATE OF DEATH: Month FEBRUARY — Day 2 — Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/1/1890
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: TOBACCO CO.
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN H. BURKHOLDER
14. MOTHER'S MAIDEN NAME: EMMA K. BARTLES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): W.W. #1
16. SOCIAL SECURITY NO.: 300-05-3319
17. INFORMANT: MRS. VIRGINIA BURKHOLDER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) (County) (State): — —

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells, M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 2-4-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/6/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Normant, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 9 '59
24b. REGISTRAR'S SIGNATURE:

VS. A15ME
5M 2/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2362 CERTIFICATE OF DEATH

Reg. Dist. No. 02355

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 18 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SHARPSBURG
d. STREET ADDRESS: SHARPSBURG MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle JACOB Last BUSSARD

4. DATE OF DEATH: Month FEBRUARY Day 10 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 9 1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (State or foreign country): SHARPSBURG WASH.CO.MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM C.BUSSARD

14. MOTHER'S MAIDEN NAME: CHARLOTTE ANN AINSWORTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT (Address): MARTIN L.BUSSARD SHARPSBURG MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
450.0
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Debility - Arteriosclerosis - Uremia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 1958, to Feb. 11, 1959, that I last saw the deceased alive on February 10, 1959, and that death occurred at 10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H Shealy M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 2/11/59

PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: FEB.13 1959
22c. NAME OF CEMETERY OR CREMATORY: LOCUST GROVE CEMETERY
22d. LOCATION (City, town, or county) (State): LOCUST GROVE WASH.CO.MD

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast
ADDRESS: Boonsboro Md.

24a. REC'D BY REGISTRAR: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2420 **CERTIFICATE OF DEATH**

02356 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO RURAL
c. LENGTH OF STAY IN 1b: 44 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BOONSBORO MD. R. 2

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO - RURAL
d. STREET ADDRESS: BOONSBORO MD. R. 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOSIE Middle — Last CONKLIN
4. DATE OF DEATH: Month FEBRUARY Day 1 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JULY 20 1865
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED OPERATOR OF BEAUTY SHOP.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BROOKLYN N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELIHAU CONKLIN
14. MOTHER'S MAIDEN NAME: ADELIA ANN GARDNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. HERBERT DOLFIELD Address: BOONSBORO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 19 57, to Feb 1, 19 59, that I last saw the deceased alive on Feb 1, 19 59, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Wilson M.D. ADDRESS (Street, city or town, state): Boonsboro Md DATE SIGNED: 2/2/59

PHYSICIAN'S NAME (Type): G. Wilson

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: FEB. 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H Rust ADDRESS: Boonsboro Md
24a. REC'D BY REGISTRAR DATE: FEB 5 '59
24b. REGISTRAR'S SIGNATURE: C Thos B Mc UA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02357

2363 # CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 35 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 16 Beckley Road

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 16 Beckley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Crosswhite

4. DATE OF DEATH: Month: 2 — Day: 18 — Year: 19 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 25, 1883

9 AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home duties

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Campbell Co. Tenn.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Abner Lovely

14. MOTHER'S MAIDEN NAME: Lucinda Murray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: none

17. INFORMANT: Jesse H. Crosswhite — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ovarian tumor with abdominal, pulmonary, and cervical metastasis and massive pleural effusion.
INTERVAL BETWEEN ONSET AND DEATH: 9 Months (certain)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardiovascular disease

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 23, 1958, to February 18, 1959, that I last saw the deceased alive on February 17, 1959, and that death occurred at 12:35 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. T. Layman M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 2/18/59

PHYSICIAN'S NAME (Type): William T. Layman, M.D. — Hagerstown — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b DATE THEREOF: 2-20-59
22c NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 19 '59

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02358

2364 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 13 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown
d. STREET ADDRESS: Route 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aurah — Middle: — Last: Cunningham

4. DATE OF DEATH: Month: 2 — Day: 18 — Year: 19 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 12, 1870

9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home duties

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Front Royal, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Garmong

14. MOTHER'S MAIDEN NAME: Margaret Rogers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Grace Warren — Address: Emmittsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease. — INTERVAL BETWEEN ONSET AND DEATH: Years.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 18, 1959 to Feb. 18, 1959 that I last saw the deceased alive on Feb. 18, 1959, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D.
ADDRESS (Street, city or town, state): 119 North Potomac St.
DATE SIGNED: Feb. 18, 1959

PHYSICIAN'S NAME (Type): R. A. Bell, M. D.
Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2-21-59
22c. NAME OF CEMETERY OR CREMATORY: Bunker Hill
22d. LOCATION (City, town, or county): Bunker Hill (State): W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 '59
24b. REGISTRAR'S SIGNATURE: C. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02359

2365 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 233 Taylor Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle GERTRUDE Last CUNNINGHAM

4. DATE OF DEATH: Month February Day 16 Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feby 17 1880
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Rockingham Co Port Republic Va.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joshua Petre
14. MOTHER'S MAIDEN NAME: Mary Alice Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: 214-09-7605
17. INFORMANT: Chester Cunningham 921 Frederick Road Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 230X
DUE TO (b): Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arterial Sclerosis due to Senility
INTERVAL BETWEEN ONSET AND DEATH: 6 mnth.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-16-59 to 2-16-59 that I last saw the deceased alive on 2-16-59, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 2/17/59

PHYSICIAN'S NAME (Type): [signature]

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/19/59
22c. NAME OF CEMETERY OR CREMATORY: Bretheren Cemetery
22d. LOCATION (City, town, or county) (State): Ringgold Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andr w H. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: FEB 20 59
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2366

Reg. Dist. No. 02360

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 38 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1102 MT. ETNA ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1103 MT. ETNA ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ISAAC — Middle: MILTON — Last: DAVIS
4. DATE OF DEATH: Month: FEBRUARY — Day: 8 — Year: 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/5/1887
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED LABORER
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION WORK
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH DAVIS
14. MOTHER'S MAIDEN NAME: LYDIA WOLFORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. REBA M. DAVIS — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary Occlusion	6 Mos
DUE TO (c)	Arteriosclerotic Heart Dis	2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1-59, 19___, to 2-8-59, 19___, that I last saw the deceased alive on 2-7-59, 19___, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. W. Dutt M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 2/9/59

PHYSICIAN'S NAME (Type): DREW DUTT — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/11/59
22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2367 CERTIFICATE OF DEATH

Reg. Dist. No. 02361

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 812 Spruce St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF [redacted] (Type or print): First: Lawrence — Middle: Ray — Last: Davis

4. DATE OF DEATH: Month: 2 — Day: 7 — Year: 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 3, 1888

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: W. Md. R.R.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Summerfield Davis

14. MOTHER'S MAIDEN NAME: Mary Frazier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 705-10-5959

17. INFORMANT: Mrs. Clara Mae Davis — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Marked emphysema & resp. failure — INTERVAL BETWEEN ONSET AND DEATH: 6 months +
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension, Arteriosclerosis, adhesions in abd.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour / a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 17 October, 1956, to 7 February, 1959, that I last saw the deceased alive on 2 February, 1959, and that death occurred at 2:55 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Richard T. Binford, M.D. — ADDRESS (Street, city or town, state): 1135 Potomac Avenue, Hagerstown, Md. — DATE SIGNED: 2/9/59

PHYSICIAN'S NAME (Type): Richard T. Binford, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 2-10-59

22c NAME OF CEMETERY OR CREMATORY: Rose Hill

22d LOCATION (City, town, or county): Hagerstown (State): Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '59

24b REGISTRAR'S SIGNATURE: [illegible] L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2368 — Reg. Dist. No. 2362

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert — Middle Chester — Last De Lauder

4. DATE OF DEATH: Month February — Day 27 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1880

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Repair

11. BIRTHPLACE (State or foreign country): Near Middletown Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert S. De Lauder

14. MOTHER'S MAIDEN NAME: Ada F. Barrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ----
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 214-16-0621

17. INFORMANT: J. Robert De Lauder — Address: Galena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Caccinoma of rectum; Acute bronchitis and

DUE TO: acute myocardial failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 30 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.: None 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State) —

21. I certify that I attended the deceased from Oct. 19 58 to Feb. 27 19 59, that I last saw the deceased alive on Feb. 27 19 59, and that death occurred at 5:10 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: S. Robert Wells M.D.
ADDRESS (Street, city or town, state): 115 N. Potomac Street
DATE SIGNED: 2-28-59

PHYSICIAN'S NAME (Type): S. Robert Wells, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-2-59
22c. NAME OF CEMETERY OR CREMATORY: Christ Reformed
22d. LOCATION (City, town, or county) (State): Middletown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2369

CERTIFICATE OF DEATH

02363

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Few minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 205 East Lincoln Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brenda — Middle: Ann — Last: Delouney

4. DATE OF DEATH: Month: February — Day: 19 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 19, 1959

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min. / Few

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Delouney

14. MOTHER'S MAIDEN NAME: Betty Jane Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mr. Charles Delouney — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO (b): Premature Delivery
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 30 MINS

776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/19, 1959, to 2/19, 1959, that I last saw the deceased alive on 2/19, 1959, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard A. Young M.D. — ADDRESS (Street, city or town, state): Hagerstown, md — DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): Richard A. Young — 101 King St

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/20/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Souzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 59

24b. REGISTRAR'S SIGNATURE

318.262X

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2364

2370 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 9 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 205 East Lincoln Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Linda — Middle: Sue — Last: Delouney

4. DATE OF DEATH: Month: February — Day: 19 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 19, 1959

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours 9, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Delouney

14. MOTHER'S MAIDEN NAME: Betty Jane Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mr. Charles Delouney — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
776X
DUE TO (b): Premature delivery
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 9 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m., p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/19, 1959, to 2/19, 1959, that I last saw the deceased alive on 2/19, 1959, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard A. Young M.D. — ADDRESS (Street, city or town, state): Hagerstown, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Richard A. Young — 101 King St. — 2/20/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/20/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Souzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 59

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2371 **CERTIFICATE OF DEATH**

02365

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 120 East Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AUGUSTUS — Middle FREDERICK — Last DIENER

4. DATE OF DEATH: Month February — Day 8 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 13, 1871

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Jewler

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Williamsport, Pennsylvania U.S.A.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustus F. Diener

14. MOTHER'S MAIDEN NAME: Josephine Kara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 212-14-7959

17. INFORMANT — Address: Mrs. Bertha E. Diener — Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(b): prostatic hypertrophia with hemorrhage. — 6 mos.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

610X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 30, 1958, to Feb 8, 1959, that I last saw the deceased alive on Feb 8, 1959, and that death occurred at 8:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C Crisp MD — ADDRESS (Street, city or town, state): 115 King St. — DATE SIGNED

PHYSICIAN'S NAME (Type): Joseph C. Crisp, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/11/1959

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '59

24b. REGISTRAR'S SIGNATURE: C. Tim L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2372

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 60 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Jackson Convalesent Home

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Laryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 105 North Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle BINGHAM Last DUNAHUGH

4. DATE OF DEATH: Month Feby. Day 13 Year 1959 19

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jany. 2 1873
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Md. Leitersburg Wash. Co
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Urias W. Bingham
14. MOTHER'S MAIDEN NAME: Susan Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Miriam Highbarger 105 North Ave Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-6-57, 19___, to 12-13-59, 19___, that I last saw the deceased alive on 2-12-59, 19___, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D.
ADDRESS (Street, city or town, state): 318 N. Potomac St.
DATE SIGNED: 2-14-59
PHYSICIAN'S NAME (Type): Paul Harrison, M. D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/15/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR: FEB 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02367

2373

CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1505 Fountain Hd. Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NILES — Middle SPEANER — Last EASTERDAY

4. DATE OF DEATH: Month February — Day 14 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 15 1899

9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Pangborn Corp.

11. BIRTHPLACE (State or foreign country): Md. Frederick, Frederick Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Easterday

14. MOTHER'S MAIDEN NAME: Cecelia Gillis

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Isabell H. Easterday 1505 Ft Head Rd Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 9 days
420.1
DUE TO (b): Arterio sclerotic (Coronary) heart disease — 2½ years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m / p. m — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/6, 19 59 to 2/14, 19 59, that I last saw the deceased alive on 2/14, 19 59, and that death occurred at 8:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H Hornbaker M.D
ADDRESS (Street, city or town, state): 154 West Washington St., Hagerstown, Md.
DATE SIGNED: 2:16:59

PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/17/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: FEB 17 '59
24b. REGISTRAR'S SIGNATURE: Esther L. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0236

2374 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 142 N. Potomac Street
d. STREET ADDRESS: Hagerstown,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JAMES	CRAIG	ELLIOTT	February	17	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	White		September 18, 1893	65 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipping clerk	Foundry	Welsh Run, Penn.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank T. Elliott	Mary Alice Hacker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes W. W. I	578-07-8459	Mrs. Helen B. Elliott Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs.

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
a. m. / p. m. 19			

21. I certify that I attended the deceased from Feb. 17, 1959 to Feb. 17, 1959 that I last saw the deceased alive on Feb. 17, 1959 and that death occurred at 6:57 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D. — ADDRESS (Street, city or state): 119 North Potomac St. — DATE SIGNED: Feb. 18, 1959.

PHYSICIAN'S NAME (Type): R.A.Bell, M.D. — Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/ 20/ 1959	Rose Hill Cemetery	Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Suter-Rouzer Funeral Home H. Franklin Rouzer	Hagerstown, Md.	FEB 24 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2421

CERTIFICATE OF DEATH

92369 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LOCUST GROVE RURAL
c. LENGTH OF STAY IN 1b: 38 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ROHRERSVILLE MD. ROUTE 1

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LOCUST GROVE RUR AL
d. STREET ADDRESS: ROHRERSVILLE MD. ROUTE 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EARL Middle Last ESHELMAN

4. DATE OF DEATH: Month FEBRUARY Day 16 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: OCTOBER 30 1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months ____ Days ____ Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): CANTON ILLINOIS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARTIN ESHELMAN

14. MOTHER'S MAIDEN NAME: AMELIA DEWITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MISS MARTHA HAYNES ROHRERSVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ____
DUE TO
(c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 16, 19 57 to Feb 16, 19 59 that I last saw the deceased alive on Feb 16, 19 59, and that death occurred at 8 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. LeCrone M.D
ADDRESS (Street, city or town, state): Boonsboro
DATE SIGNED: 2/17/59

PHYSICIAN'S NAME (Type): G. W. LeCrone Md.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: FEB. 19 1959
22c. NAME OF CEMETERY OR CREMATORY: LOCUST GROVE CEMETERY
22d. LOCATION (City, town, or county) (State): LOCUST GROVE WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast
ADDRESS: Boonsboro Md

24a. REC'D BY REGISTRAR DATE: FEB 2 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hawk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2375 CERTIFICATE OF DEATH

Reg. Dist. No. 02370

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 ½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 155 S. Mulberry Street

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Keedysville RFD
d. STREET ADDRESS: Keedysville RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Hugh; Middle Oliver; Last Fisher
4. DATE OF DEATH: Month Feb.; Day 22; Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 28 1885
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months 4; Days 4
IF UNDER 24 HRS: Hours; Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd Farm Owner
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Eakles Mill Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John A. Fisher
14. MOTHER'S MAIDEN NAME: Catherine Kefauver
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO: 215 20 8561
17. INFORMANT: Mrs. Albert Bowers Address 12 Fourth Street Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Hrs
DUE TO (b): Arteriosclerosis, Heart — Years
DUE TO (c): Hypertension, Hardening of Arteries — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from Feb 1, 1959 to Feb 22, 1959, that I last saw the deceased alive on Feb 18, 1959, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D. ADDRESS (Street, city or town, state): 159 W. Washington St., Hagerstown, Md. DATE SIGNED: 2/23/59

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 25-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town or county) (State): Sharpsburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leaf ADDRESS: Williamsport Md
24a. REC'D BY REGISTRAR DATE: FEB 25 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2376 CERTIFICATE OF DEATH

02371

Reg. Dist. No. 301

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 61 North Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA — Middle MARGARET — Last GEARY

4. DATE OF DEATH: Month February — Day 21 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 6, 1882

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christopher G. Boryer

14. MOTHER'S MAIDEN NAME: Margaret Garmen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mrs. Margaret Stoner Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Leukemia - myeloid - chronic — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs 2 mo.

204,1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1957 to Feb. 21, 1959 that I last saw the deceased alive on Feb. 21 1959, and that death occurred at 1:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd A. Hoffman M.D. — ADDRESS (Street, city or town, state): 214 N. Potomac St. Hagerstown, Md. — DATE SIGNED: 2/23/59

PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/24/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: DATE FEB 25 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2377 CERTIFICATE OF DEATH

02372

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 830 Potomac Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 830 Potomac Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLINTON — Middle FISK — Last GIBBONS

4. DATE OF DEATH: Month February — Day 28 — Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 8, 1890

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired machinest

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Poconoke City, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Noah Gibbons

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: 705-10-6810

17. INFORMANT: Mrs. Gertrude Gibbons — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
420.0
DUE TO
(b): Arteriosclerotic Heart Dis. — years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous Myocardial infarction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____ 19____, to _____ 19____, that I last saw the deceased alive on Never seen alive 19__, and that death occurred at 8.30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D. — ADDRESS (Street, city or town, state): 1135 Potomac Ave. Hagerstown, Md. — DATE SIGNED: 1 Mar 59

PHYSICIAN'S NAME (Type): Richard T. Binford

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/3/1959

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 5 '59

24b. REGISTRAR'S SIGNATURE: Clifton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02373

2378 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greencastle
d. STREET ADDRESS: 115 N. Allison St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Karl — Middle: M. — Last: Glaser
4. DATE OF DEATH: Month: February — Day: 3 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/19/1896
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days / IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Carrier
10b. KIND OF BUSINESS OR INDUSTRY: Rural Mail Carrier
11. BIRTHPLACE (State or foreign country): Franklin Co. Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles B. Glaser
14. MOTHER'S MAIDEN NAME: Laura Brindle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Rhoda B. Glaser — Address: Greencastle, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary arteriosclerosis with thrombosis and resultant myocardial infarction.	6 hours.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1/ 19 39, to 2/2/ 19 59 that I last saw the deceased alive on 2/2/59 19 , and that death occurred at 5:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W.C. Brewer M.D — ADDRESS (Street, city or town, state): 359 E. Baltimore St., Greencastle, Penna. — DATE SIGNED: 2/3/59

PHYSICIAN'S NAME (Type): W.C. Brewer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/5/1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Greencastle Franklin Co. Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Harold M. Zimmerman — ADDRESS: Greencastle, Pa

24a. REC'D BY REGISTRAR DATE: FEB 5 '59
24b. REGISTRAR'S SIGNATURE: Curtis L. Hess

VS 15 (4)
15M 11/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2379

CERTIFICATE OF DEATH

Reg. Dist. No. 02374

1. PLACE OF DEATH
a. COUNTY Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 54 years

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Martin Manor Nursing Home
d. STREET ADDRESS: 442 Mechanic St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Singleton Middle Tillberry Last Grandstaff
4. DATE OF DEATH: Month February Day 11 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 23, 1878
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Near Luray Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Singleton T. Grandstaff
14. MOTHER'S MAIDEN NAME: Laura Carpenter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 215-18-1996
17. INFORMANT: Mrs. Birtie D. Grandstaff Address: Hagerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24hrs
DUE TO
(b) Hypertension & Arterio Sclerosis — 4yrs
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
93IX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Had T&R 4 years ago 12/27/55
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 22 Dec., 19 58, to 11 Feb., 19 59, that I last saw the deceased alive on 10 Feb., 19 59, and that death occurred at 5:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Eldon G. Hoachlander M.D.
ADDRESS (Street, city or town, state): 115 W. Washington St.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Eldon G. Hoachlander Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-13-59
22c. NAME OF CEMETERY OR CREMATORY: Beahm Chapel Cemetery
22d LOCATION (City, town, or county) (State): Near Luray Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kranz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2422 — Reg. Dist. No. 02375

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be perfected with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 15 (4) 1 9/55

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Hook — c. LENGTH OF STAY IN 1b: 45 yrs/	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sandy Hook
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Residence	d STREET ADDRESS: / Main Street — e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	WILLIAM	GREENWALT	Feb. 23,		1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Male	White		Jan. 26, 1902	57 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trackman (Ret.)	Railroad	Loudoun County, Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Abraham Greenwalt	Mary Magdaline Mirley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW II	705-05-9522	Mrs. Mazie Hackley RFD#1, Knoxville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS

4 .1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-22, 19 59, to 2-23, 19 59, that I last saw the deceased alive on 2-23, 19 59, and that death occurred at 12:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Chipchicas M.D. — ADDRESS (Street, city or town, state): 15 S. MARYLAND Ave — DATE SIGNED

PHYSICIAN'S NAME (Type): C. T. BYRON KAO — BRUNSWICK Md 2-25-59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/26/59	Ebenezer Cemetery	Loudoun County, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
A. Donald Zackley	Harpers Ferry, W.Va.	FEB 27 1959	Orby L. Kerns

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2380 **CERTIFICATE OF DEATH** 0237

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 45 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 143 West Side Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Aaron Middle Newton Lost Grimm Sr.
4. DATE OF DEATH Month February Day 19 Year 19 59
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH February 3, 1893
9. AGE (In years last birthday) 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker
10b. KIND OF BUSINESS OR INDUSTRY Aircraft
11. BIRTHPLACE (State or foreign country) Bakerton W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Thomas Grimm
14. MOTHER'S MAIDEN NAME Margaret Fowlby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. I
16. SOCIAL SECURITY NO. 217-07-0680
17. INFORMANT Mrs. Mary E. Grimm Address Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion & Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH 5 hours
420.1
DUE TO (b) Arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
Diabetes Mellitus; Hist Coronary occlusion 1942 c/o

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Nov 19 50, to 19 Feb 19 59, that I last saw the deceased alive on 19 Feb 19 59, and that death occurred at 1:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Eldon G Hoachlander M.D.
ADDRESS (Street, city or town, state) 115 W. Washington St.
DATE SIGNED
PHYSICIAN'S NAME (Type) Eldon G. Hoachlander Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-23-59
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State) Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE FEB 24 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2381 CERTIFICATE OF DEATH

Reg. Dist. No. 12377

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 yr. 2 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: 106 E. Salisbury Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Jacob	Henry	Gruber	Feb.	26	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Male	White		Jan. 4 1870	89 yrs.	1	21		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Grocery Store	Williamsport Md.	U.S.A

13. FATHER'S NAME: Samuel Gruber
14. MOTHER'S MAIDEN NAME: Catherine Brubaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	
No	No	213 24 9910	Mr. Vernon Gruber	4 S. Conococheague St. Williamsport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 1 Day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					

21. I certify that I attended the deceased from 2-25-59 19 ____ to 2-26-59 19 ____ that I last saw the deceased alive on 2-26-59 19 ____, and that death occurred at 10P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Flora Jr. M.D. — ADDRESS (Street, city or town, state): Williamsport Md. — DATE SIGNED: 2/27/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	Feb. 28-59	Riverview Cemetery	Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS: Albert L. Kirkpatrick Williamsport Md.

24a REC'D BY REGISTRAR DATE MAR 2 '59

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

I

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2382

Reg. Dist. No. 02378

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): In Automobile -1600 Blk Jefferson Blvd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cavetown
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: H — Last: Mahlon Harrison

4. DATE OF DEATH: Month: Feb. — Day: 16 — Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 10, 1893

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): welder & machinist

10b. KIND OF BUSINESS OR INDUSTRY: machine shop

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mahlon Harrison

14. MOTHER'S MAIDEN NAME: Susan L. Bett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 214-09-2328

17. INFORMANT: Mrs. Harry Harrison, Address: Rd 3, Hag., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic myocardial heart disease
DUE TO (b): Acute coronary thrombosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): None

20c. TIME OF INJURY: Hour: a. m. / p. m. None — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) (County) (State): - - -

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: 2-17-59

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 2-19-59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. REC'D BY REGISTRAR: DATE FEB 19 '59

24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 238 2-13-59 ams Film 238 2-13-59 ams

CERTIFICATE OF DEATH

2383 Reg. Dist. No. 12379

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 24 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, near Letiersburg
d. STREET ADDRESS: Hagerstown #5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cyrus — Middle: Cleveland — Last: Hartle

4. DATE OF DEATH: Month: Feb. — Day: 7 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/25/1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired, R.R. Employee

10b. KIND OF BUSINESS OR INDUSTRY: Western Maryland

11. BIRTHPLACE (State or foreign country): Leitersburg #5

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Hartle

14. MOTHER'S MAIDEN NAME: Mary E. Hemphill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address: Mrs. Ida Kriner, Waynesboro Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (b) Resultant and live
IMMEDIATE CAUSE (a): CARCINOMA LEFT LUNG WITH METASTASIS TO — INTERVAL BETWEEN ONSET AND DEATH: 3 MONTHS
DUE TO (a): CONFLUENT LOBULAR PNEUMONIA - BILATERAL — 1 WEEK
DUE TO (b): CARCINOMA OF PROSTATE WITH Carcinoma of bladder — 5 YEARS plus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN. 14, 19 59 to FEB 7, 19 59, that I last saw the deceased alive on Feb 7, 19 59, and that death occurred at 7:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Evaristo R. Laodizabal M.D. — ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE — DATE SIGNED: 2-7-59

PHYSICIAN'S NAME (Type): Evaristo R. Laodizabal — Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/10/59

22c. NAME OF CEMETERY OR CREMATORY: Leitersburg

22d. LOCATION (City, town, or county) (State): Leitersburg, Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y Stover — ADDRESS: Waynesboro Pa

24a. REC'D BY REGISTRAR DATE: FEB 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2384

Reg. Dist. No. 22380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro 75 x - 3
d. STREET ADDRESS: 156 Ridge Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ernest Middle O. Last Hess
4. DATE OF DEATH: Month 2 Day 8 Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/9/1895
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machenist
10b. KIND OF BUSINESS OR INDUSTRY: Landis Machine Co.
11. BIRTHPLACE (State or foreign country): Martinsburg, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Hess
14. MOTHER'S MAIDEN NAME: Annie Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 173-03-3875
17. INFORMANT: Address: Mrs. Ernest O. Hess 156 Ridge Ave. Waynesboro Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b) Massive thrombosis (cerebral) — 4 wks.
DUE TO
(c) Arteriosclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/16, 1959, to 2/8, 1959, that I last saw the deceased alive on 2/8, 1959, and that death occurred at 8:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A. F. Abdullah M.D.
ADDRESS (Street, city or town, state): 132 N. Potomac Street, Hagerstown, Maryland
DATE SIGNED: 2/9/59
PHYSICIAN'S NAME (Type): A. F. Abdullah, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/12/1959
22c. NAME OF CEMETERY OR CREMATORY: Green Hill
22d. LOCATION (City, town, or county) (State): Waynesboro, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Grove
ADDRESS: Waynesboro Pa.
24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2385 CERTIFICATE OF DEATH

Reg. Dist. No. 02381

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1034 Security Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Michael — Middle ---- — Last Horvath
4. DATE OF DEATH: Month February — Day 19 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 2, 1887
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Operator
10b. KIND OF BUSINESS OR INDUSTRY: Cement
11. BIRTHPLACE (State or foreign country): Hungary
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Istvan Horvath
14. MOTHER'S MAIDEN NAME: Julia Varga

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ---- (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 213-10-6767
17. INFORMANT: Miss Ilona Racz — Address: Tronto Canada

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis Renal — 5 yrs.
DUE TO
(c): Diabetes Mellitus. — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 26, 19 58, to Feb 19, 19 59, that I last saw the deceased alive on Feb 18, 19 59, and that death occurred at 7 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Phillip J. Hirshman, M.D.
ADDRESS (Street, city or town, state): 159 W. Washington St.
DATE SIGNED: 2/20/59
PHYSICIAN'S NAME (Type): Phillip J. Hirshman — Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-21-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: FEB 24 '59
24b. REGISTRAR'S SIGNATURE: C. Paul L. Frantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2386 **CERTIFICATE OF DEATH**

02382

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 34 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 613 Sunset Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 613 Sunset Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: Loretta — Last: Humelsine

4. DATE OF DEATH: Month: February — Day: 26 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1878

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mooresville, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John A. Moore

14. MOTHER'S MAIDEN NAME: Margaret J. Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: none

17. INFORMANT — Address: Miss. Mary T. Humelsine Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

4.45X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 19 57, to Feb 26, 19 57, that I last saw the deceased alive on Feb 25, 19 57, and that death occurred at 4:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert P. Conrad, MD — ADDRESS (Street, city or town, state): 137 W. Washington — DATE SIGNED: 2-22-57

PHYSICIAN'S NAME (Type): Robert P. Conrad — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/28/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter & Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Frana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 2423 — 02282

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg Md RFD #1
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Antietam

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg Md RFD #1
d. STREET ADDRESS: Antietam
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	Luther	Jamison Jr.	Feb.	12	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Male	White		June 24 1950	8 yrs.	7	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	Public School	Hagerstown Md.	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Luther Jamison Sr.	Altha Mae Crampton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	No	None	John Luther Jamison Sr.	Antietam Sharpsburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Measles - Dec. 1958; Bronchial asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
none	19		none	-	-	-

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-14-59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb. 15-59	Mt. View Cemetery	Sharpsburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
[illegible]	Williamsport, Md.	FEB 17 '59	[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

Items 18-21 Fi[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2387

Reg. Dist. No. 02384

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: Hamilton Hotel- W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Ross — Last: Jensen
4. DATE OF DEATH: Month: 2 — Day: 7 — Year: 19 59
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 4, 1903
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Hotel Hamilton
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl John Jensen
14. MOTHER'S MAIDEN NAME: Maria Hendrickson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 577-01-5836
17. INFORMANT: Mrs. Audrey Jensen — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): /Undetermined/ /pending/ autopsy/ report/
DUE TO (b): Acute barbiturate poisoning
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 871.9
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): /Undetermined yet/ none
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year: ??None 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --
20f. (City or town) (County) (State): --

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-9-59

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2-10-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: C. Mac L. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2.57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2388

02385 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 16: 14 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 315 FREDERICK STREET
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle T. — Last KEPHART
4. DATE OF DEATH: Month FEBRUARY — Day 26 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 26 1896
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINTENANCE DEPT.
10b KIND OF BUSINESS OR INDUSTRY: FAIRCHILD AIRCRAFT
11. BIRTHPLACE (State or foreign country): MYERSVILLE FRED.CO.MD.U.S.A.
12 CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: NO RECORD
14. MOTHER'S MAIDEN NAME: ALMA ALEXANDER
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 224 20 7150
17. INFORMANT: MRS.ROOSEVELT GILARDI — Address: BOONSBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Multiple fracture of ribs and sternum	16 hrs
DUE TO (b)	Open fracture left patella	16 hrs
DUE TO (c)	Acute ventricular fibrillation	

823X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Driver of car that hit a tree when car failed to negoitate a curve
20c. TIME OF INJURY Month, Day, Year: Hour 6:15 P m — Feb. 25 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): Rural-Smbg, Wash Md

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells — M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2-27-59

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a BURIAL CREMATION REMOVAL Specify: BURIAL
22b. DATE THEREOF: MARCH 1 1959
22c. NAME OF CEMETERY OR CREMATORY: LUTHERAN CEMETERY
22d LOCATION (City, town, or county) (State): MIDDLETOWN FRED.CO.MD.

23 FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — ADDRESS: Boonsboro Md
24a REC'D BY REGISTRAR DATE: MAR 2 59
24b. REGISTRAR'S SIGNATURE: Curt L. Frana

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2424

CERTIFICATE OF DEATH

Reg. Dist. No. 02381

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
c. LENGTH OF STAY IN 1b: 3 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Farmney- Keedy Home

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 321 West Side Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIE Middle VELONA Last KIRACOFE

4. DATE OF DEATH: Month February Day 5 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 19 1870

9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Downsville Fred Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Stroh

14. MOTHER'S MAIDEN NAME: Elizabeth Landis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mrs Pauline Snyder Walkersville
Address: Fred. Co Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH: 10yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ____
DUE TO
(c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a m p. m Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 2, 1958 to Feb. 5, 1959, that I last saw the deceased alive on Feb. 4, 1959, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M D
ADDRESS (Street, city or town, state): Boonsboro, Md.
DATE SIGNED: 2/6/59

PHYSICIAN'S NAME (Type): G. W. Leuzinger

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/8/59

22c. NAME OF CEMETERY OR CREMATORY: River View Cemetery

22d. LOCATION (City, town, or county) (State): Williamsport Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: FEB 9 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [illegible] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2425

CERTIFICATE OF DEATH

9238?

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 2
c. LENGTH OF STAY IN 1b: 25 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Pike

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ssion)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown R # 2
d. STREET ADDRESS: Western Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First BERT Middle EUGENE Last KITZMILLER

4. DATE OF DEATH: Month February Day 3 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 16 1884

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Enos Kitzmiller

14. MOTHER'S MAIDEN NAME: Clara Hammersla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Corinne R. Kitzmiller Address: Hagerstown Md. R # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 2 months

1017X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 3, 1958 to Feb. 3, 1959 that I last saw the deceased alive on Feb. 2, 1959, and that death occurred at 7:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David R. Brewer M.D. ADDRESS (Street, city or town, state): Clear Spring Md DATE SIGNED: 2/6/59

PHYSICIAN'S NAME (Type): David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/6/59

22c. NAME OF CEMETERY OR CREMATORY: St Paule Cemetery near Clear Spring Wash. Co

22d. LOCATION (City, town, or county) (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: FEB 3 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2389 CERTIFICATE OF DEATH

Reg. Dist. No. 02389

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md
c. LENGTH OF STAY IN 1b: 3 Wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hancock Maryland.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Harry Middle Bertum Last Lashley

4. DATE OF DEATH: Month 2 Day 22 Year 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 24. 1895

9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months 8 4 Days 28
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Fulton County Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles G Lashley

14. MOTHER'S MAIDEN NAME: Rebecca J Nycum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: James E Lashley Penna. Ave. Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gas Gangrene Lft Leg
DUE TO (b): Arterio Sclerotic Obliterative Vascular Disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4 Feb, 1959 to 22 Feb, 1959 that I last saw the deceased alive on 21 Feb, 1959, and that death occurred at 9 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank E Brumback M D
ADDRESS (Street, city or town, state): 170 west Washington ST
DATE SIGNED:
PHYSICIAN'S NAME (Type): Frank E Brumback Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2.25.59

22c. NAME OF CEMETERY OR CREMATORY: Rehobeth Methodist

22d. LOCATION (City, town, or county) (State): Fulton County Penna.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Howard J Stone Hancock md

24a. REC'D BY REGISTRAR DATE: FEB 27 '59

24b. REGISTRAR'S SIGNATURE: C[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2390 CERTIFICATE OF DEATH

Reg. Dist. No. 2355

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 149 N. Potomac St.,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First John — Middle P — Last Lawrence

4. DATE OF DEATH: Month 2 — Day 17 — Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 31, 1873

9. AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: silk weaver

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: unknown

14 MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-2801

17. INFORMANT: Mrs. Ethel Lorshbaugh — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
(b): Cerebral Arteriosclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 12, 1959, to Feb 17, 1959, that I last saw the deceased alive on Feb 17 8:30 A, 1959, and that death occurred at 11:59 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John D Turco MD M.D. — ADDRESS (Street, city or town, state): 302 N Potomac St — DATE SIGNED:

PHYSICIAN'S NAME (Type): John D Turco MD — Hagerstown MD

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 2-21-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2391 CERTIFICATE OF DEATH

02390

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: TWO DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SHARPSBURG
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DUANE Middle ERIC Last MARSHALL

4. DATE OF DEATH: Month FEBRUARY Day 3 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY-1-1959

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months — Days TWO
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): HAGERSTOWN WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LUTHER MARSHALL

14. MOTHER'S MAIDEN NAME: ALICE POOLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or date of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: LUTHER MARSHALL Address: SHARPSBURG MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bilateral atalectasis with hyaline membrane	2 days
DUE TO	Bilateral tears of the tentorium cerebelli	2 Days
DUE TO	Prematurity -- 1 month.- birth injury.	

760.5 ~~XXXX~~

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from birth 19 to Feb. 3 19 59 that I last saw the deceased alive on Feb. 2, 1959 19 and that death occurred at 9:30A M, from the causes and on the date stated above

ACTUAL SIGNATURE: Walter H. Sheely M.D

ADDRESS (Street, city or town, state): Sharpsburg, Md.

DATE SIGNED: Feb. 3, 59

PHYSICIAN'S NAME (Type): Walter H. Sheely M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: FEB 4 1959

22c NAME OF CEMETERY OR CREMATORY: SAMPLES MANOR CEMETERY

22d LOCATION (City, town, or county) (State): SAMPLES MANOR WASH. Co. MD.

23 FUNERAL DIRECTOR'S SIGNATURE: John H. Bast

ADDRESS: BOONSBORO MD

24a. RECD BY REGISTRAR DATE: FEB 6 59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02391

2392 **CERTIFICATE OF DEATH**

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 12 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 111 No Locust St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle MIDDLEKAUFF-McBRIDE Last
4. DATE OF DEATH: Month February Day 13 Year 1959

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Female	White		November 8 1884	74 yrs				

10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Yarrowsburg Wash. Co Md.	USA

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Lewis P. Kaetzel	Laura M. Fouch

15. WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT Address
No	------	None	William F. McBride 111 No Locust St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Pneumonitis LLL	3 days.
DUE TO (b)	Pulmonary edema	6-8 mos.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive, arteriosclerotic heart disease. Terminal

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that I attended the deceased from 23 JUNE, 19 57, to 13 FEBRUARY 19 59, that I last saw the deceased alive on 13 FEBRUARY, 19 59, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D. ADDRESS (Street, city or town, state): 1135 POTOMAC AVENUE DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): RICHARD T. BINFORD, M. D. HAGERSTOWN, MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/16/59	Rose Hill Cemetery	Hagerstown Wash Co Md

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a REC'D BY REGISTRAR	24b REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	FEB 17 '59	Clarence E. Trundle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2426 CERTIFICATE OF DEATH

Reg. Dist. No. 0232

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
c. LENGTH OF STAY IN 1b: 1 Yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hancock Nursing Home

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY: Morgan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Largent
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LuLu — Middle B. — Last McKee

4. DATE OF DEATH: Month Feb. — Day 14, — Year 1959

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 21, 1875

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months 10 Days 23 — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Morgan County, W. Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob Hutchinson

14. MOTHER'S MAIDEN NAME: Margaret Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mrs Irvin Ambrose, Largent, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Embolism — INTERVAL BETWEEN ONSET AND DEATH: Unknown

153.0

DUE TO (b): Carcinoma of ascending colon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1959, to Jan 2, 1959, that I last saw the deceased alive on Jan 2, 1959, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H E Tabler M D — ADDRESS (Street, city or town, state): Hancock Md — DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): H. E. Tabler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/18/1959

22c. NAME OF CEMETERY OR CREMATORY: Enon Ch. Cem.

22d LOCATION (City, town, or county) (State): Largent, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: PARKS FUNERAL HOME, BERKELEY SPGS, W VA.

24a. REC'D BY REGISTRAR DATE: FEB 16 59

24b. REGISTRAR'S SIGNATURE: Charles J. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2393

2393 CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 27 Mealey Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER Middle WILLIAM Last McPHAIL
4. DATE OF DEATH: Month February Day 5 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 6 1907
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Baltomdre City Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John McPhail
14. MOTHER'S MAIDEN NAME: Clementine Lerritt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Mary McPhail 27 Mealey Parkway Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure on basis of Hypertensive Atheromatous Cardiovascular Disease.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 11, 1958 to Feb. 5, 1959 that I last saw the deceased alive on Feb. 5, 1959, and that death occurred at 5:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D.
ADDRESS (Street, city or town, state): 119 North Potomac Street, 2-6-59
DATE SIGNED
PHYSICIAN'S NAME (Type): R.A.Bell, M.D. Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/8/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: FEB 9 59
24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2394 **CERTIFICATE OF DEATH** Reg. Dist. No. 02394

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FAIRPLAY RURAL
d. STREET ADDRESS: FAIRPLAY MD.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

Dr. Burkett

3. NAME OF DECEASED (Type or print): First VICTOR Middle MILTON Last METZ
4. DATE OF DEATH: Month FEBRUARY Day 8 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: FEB. 27 - 1876
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER. OWN FARM
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ROHRERSVILLE WASH. Co MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: JACOB METZ
14. MOTHER'S MAIDEN NAME: JANE GRIMM
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: MRS. WALTER GREEN FAIRPLAY MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO
4541
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1 1958 to Feb 8 1959 that I last saw the deceased alive on Feb 6 1959, and that death occurred at 7:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: M Bryhit M.D. ADDRESS (Street, city or town, state): 28 W Potomac Hagerstown Md DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: FEB. 11. 1959
22c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO MD. ROUTE 1
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John H. Bast BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE: FEB 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kinsey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0239

2395 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 27 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1002 Salem Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle CLIFFORD — Last MILLER

4. DATE OF DEATH: Month February — Day 25 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 9 1881

9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lunber Dealer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Va. Bluemont Loudon Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles W. Miller

14. MOTHER'S MAIDEN NAME: Rose Amelia Branham

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO: None

17. INFORMANT: Beaudric C. Miller
Address: 607 W. Washington St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 29 hrs.

DUE TO (b): Generalized Arteriosclerosis. — ?

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

33/X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 24, 1959 to Feb. 25, 1959 that I last saw the deceased alive on February 25, 1959, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A. Bell M.D.

ADDRESS (Street, city or town, state): 119 North Potomac Street, Hagerstown, Maryland.

DATE SIGNED: 2-27-59

PHYSICIAN'S NAME (Type): R.A.Bell,M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/28/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '59

24b. REGISTRAR'S SIGNATURE: Cathy L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2396 CERTIFICATE OF DEATH

Reg. Dist. No. 0239[illegible]

1. PLACE OF DEATH
a. COUNTY Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Fairground Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 106 Fairground Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MATTIE Middle EVA Last MOORE

4. DATE OF DEATH Month Feb. Day 13 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 2, 1890
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Fulton County, Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lewis Evan Mills
14. MOTHER'S MAIDEN NAME Christine Houch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mr. H. M. Moore 106 Fairground Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia	3 days
DUE TO (b)	Retroperitoneal Reticulum cell Sarcoma	3 months
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 27, 1958, to Nov 13, 1959, that I last saw the deceased alive on Nov 13, 1959, and that death occurred at 6:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE John D. Turco M.D. ADDRESS (Street, city or town, state) 302 N. Potomac St Hagerstown MD DATE SIGNED 2-13-59

PHYSICIAN'S NAME (Type) JOHN D. TURCO

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/16/59
22c. NAME OF CEMETERY OR CREMATORY St. Paul Church Cemetery
22d. LOCATION (City, town, or county) (State) St. Paul Washington Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE FEB 17 '59
24b. REGISTRAR'S SIGNATURE [illegible]

Wm. A. Horst O-Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2427 **CERTIFICATE OF DEATH** Reg. Dist. No. 02397

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLEVELANDVILLE RURAL
c. LENGTH OF STAY IN 1b: 50 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BOONSBORO MD.ROUTE 2

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLEVELANDVILLE RURAL
d. STREET ADDRESS: BOONSBORO MD.ROUTE 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EZRA Middle JACOB Last MOSER

4. DATE OF DEATH: Month FEBRUARY Day 14 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: APRIL 1 1877 FEBRUARY 14 1959

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED TEACHER

10b. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOL

11. BIRTHPLACE (State or foreign country): NEAR MYERSVILLE FRED.CO.MD.U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ABRAHAM MOSER

14. MOTHER'S MAIDEN NAME: ELIZABETH SCHILDTKNECHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MRS.CARRIE MOSER BOONSBORO MD.ROUTE 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-vascular - renal disease — INTERVAL BETWEEN ONSET AND DEATH: 5 Yr (?)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Uremia - caused by above — 1 week.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1, 1959, to 2/14/59, 19, that I last saw the deceased alive on Feb. 13, 1959 and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Sheely M.D.

ADDRESS (Street, city or town, state): Sharpsburg, Md.

DATE SIGNED: 2/16/59

PHYSICIAN'S NAME (Type): Walter H. Sheely M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: FEB.17 1959

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH.CO.MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast

ADDRESS: Boonsboro Md

24a. REC'D BY REGISTRAR DATE: FEB 20 '59

24b. REGISTRAR'S SIGNATURE: C. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1 B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2428 — Reg. Dist. No. 12398

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Sharpsburg
c. LENGTH OF STAY IN 1b: 6 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sharpsburg R.F.D. #1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: W shington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Sharpsburg (Taylor's Landing)
d. STREET ADDRESS: Sharpsburg R. F. D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard — Middle H — Last Petters

4. DATE OF DEATH: Month Feb. — Day 12 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Feb 23. 1905

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Past Engineer Fort Ritchie
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lancaster
12. CITIZEN OF WHAT COUNTRY: Amer.

13. FATHER'S NAME: Late Richard T. Petters
14. MOTHER'S MAIDEN NAME: Augusta Fenske

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W. W II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Oscar Petters 201 Ruby Lt Lancaster

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO (b): Coronary Sclerosis — 3 yrs. (?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 1957 to Feb 12, 1959 that I last saw the deceased alive on Feb. 9, 1959, and that death occurred at 9 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Walter H Shealy M.D
ADDRESS (Street, city or town, state):
DATE SIGNED: Feb. 12, 1959.

PHYSICIAN'S NAME (Type): Walter H. Shealy M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-16-59
22c. NAME OF CEMETERY OR CREMATORY: Conestoga Memorial
22d. LOCATION (City, town, or county) (State): Lancaster Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Gilbert E Leaf
ADDRESS: Williamsport, Md.

24a. RECEIVED BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: C Thurston Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2429 — 02399 — Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Rt.
c. LENGTH OF STAY IN 1b: 73 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): [illegible] in Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg Md.
d. STREET ADDRESS: 114 East Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allen — Middle: Luther — Last: Poffenberger
4. DATE OF DEATH: Month: Feb. — Day: 4 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10 1885
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible] School Principal
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Sharpsburg Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: Otho Poffenberger
14. MOTHER'S MAIDEN NAME: Elizabeth Welsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): [illegible] — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 219 24 5104
17. INFORMANT: Mrs. Dora Poffenberger — Address: 114 E. Main St. Sharpsburg Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilateral retinitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from at death, 19___ to ___, 19___, that I last saw the deceased alive on Feb. 4, 19 59, and that death occurred at 5.15A M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Walter H Shealy M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 2/5/59.
PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
22b. DATE THEREOF: Feb. 7 1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town, or county) (State): Sharpsburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] Sharpsburg Md
24a. REC'D BY REGISTRAR DATE: FEB 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kiess

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02490

2397 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Western Md. State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 603 No Prospect St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	Henry	Powers	Feb.	15	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		December 12 1881	77 yrs.				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stone Mason	Self Employed	Colinsville Penna	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Powers	Eliza Easton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16 SOCIAL SECURITY NO.	17. INFORMANT Address
No	------	217-18-8998	Mrs Mae Babb 603 No Prospect St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 days

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) thrombosis of left circumflex artery & left auricle — 7 days

DUE TO

(c) arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cerebral thrombosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that I attended the deceased from January 15. 1959, to February 15. 1959, that I last saw the deceased alive on February 15, 1959, and that death occurred at 7:32 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L Ramos, M.D. — ADDRESS (Street, city or town, state): Western Md. State Hospital — DATE SIGNED: Feb. 15, 1959

PHYSICIAN'S NAME (Type): Victor L, Ramos — Hagerstown, Md.

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
Burial	2/18/59	Brethern Cemetery	Brownsville Wash. Co Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	FEB 17 '59	Clifford L. Keller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2398

12401

Reg Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): enroute to Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Ohio
b. COUNTY: Summit
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Akron
d. STREET ADDRESS: 5046 W. Bath Road, Rd. #7
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grover — Middle: Ernest — Last: Putman, jr.

4. DATE OF DEATH: Month: Feb. — Day: 8 — Year: 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-22-35

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): North Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Grover Ernest Putman, Sr.

14. MOTHER'S MAIDEN NAME: Barbara Langley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1952 to DOD

16. SOCIAL SECURITY NO: 280-28-3237

17. INFORMANT — Address: Official Navy Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull
DUE TO (b): Multiple fractured ribs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Fractured (closed) rt tibia & fibula
hemorrhage & shock

INTERVAL BETWEEN ONSET AND DEATH: 40 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Lost control of automobile and ran into side abutment of bridge

20c. TIME OF INJURY — Hour: 1:30 p. m. — Month, Day, Year: Feb. 8 59

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Funkstown Bridge

20f. (City or town): Hagerstown (County): Wash. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.

EXAMINER'S NAME (Type): S. Robert Wells, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Feb. 9 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-16-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest Adams — ADDRESS: Adams Funeral Home, 4748 Wisc. Ave, NW, Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: FEB 1[illegible] '59

24b. REGISTRAR'S SIGNATURE: C. Clarke [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the [illegible] case, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2399 CERTIFICATE OF DEATH

Reg. Dist. No. 02402

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 45 EAST AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First PAUL — Middle EDGAR — Last REECHER

4. DATE OF DEATH: Month FEBRUARY — Day 17 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 10/1/1921

9. AGE (In years last birthday): 37 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTING OFFICER

10b KIND OF BUSINESS OR INDUSTRY: U.S. AIR FORCE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES R. REECHER

14 MOTHER'S MAIDEN NAME: MABEL REYNOLDS

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. #2

16 SOCIAL SECURITY NO: 216-14-5841

17 INFORMANT: MRS. GENEVIEVE REECHER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myelogenous Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 Feb, 19 54, to 17 Feb, 19 54, that I last saw the deceased alive on 16 Feb, 19 54, and that death occurred at 6:34 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F F Lusby M.D. — ADDRESS (Street, city or town, state): 230 N Potomac Hagerstown Md — DATE SIGNED: 18 Feb 59

NAME (Typo): F F Lusby

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/19/59

22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

22d LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: A. J. Hormut, Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: FEB 20 '59

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2400 **CERTIFICATE OF DEATH**

02403

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 month 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 331 Linganore Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle LOUISE Last REEL

4. DATE OF DEATH: Month February Day 8 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 14, 1907

9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Coover Kniesley

14. MOTHER'S MAIDEN NAME: Bessie May Fiegley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: none

17. INFORMANT: Benjamin F. Reel Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronema — Stenosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 3, 19[illegible] to Feb. 8, 19 59, that I last saw the deceased alive on Feb. 8, 19 59, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D.

ADDRESS (Street, city or town, state): 159 W. Washington St., Hagerstown, Md.

DATE SIGNED: 2/9/59

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/11/1959

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home R. Franklin Rouzer

ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '59

24b. REGISTRAR'S SIGNATURE: [illegible] L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2401 CERTIFICATE OF DEATH

Reg. Dist. No. 02404

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 4 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SAN MAR
d. STREET ADDRESS: BOONSBORO MD. R.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GARY Middle EDWIN [redacted] Last REESE

4. DATE OF DEATH: Month FEBRUARY Day 7 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 6 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours 4 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): HAGERSTOWN MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARVIN REESE

14. MOTHER'S MAIDEN NAME: OTHELIA E. RIDENOUR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MARVIN REESE Address: BOONSBORO MD. R.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): [illegible]
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 6, 19[illegible], to Feb 7, 19[illegible] that I last saw the deceased alive on Feb 6, 19[illegible], and that death occurred at 2 [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 2/7/59

PHYSICIAN'S NAME (Type): G. Wilson [illegible] Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: FEB. 7. 1959

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H Bast ADDRESS: Boonsboro Md

24a. REC'D BY REGISTRAR DATE: FEB 10 '59

24b REGISTRAR'S SIGNATURE: C. H. [illegible] & Sons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2430

Reg. Dist. No. 02405

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SAN MAR RURAL
c. LENGTH OF STAY IN 1b: 4 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAHRNEY KEEDY MEMORIAL HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WOODLAWN
d. STREET ADDRESS: 1618 ROLLING ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle E. Last RINEHART

4. DATE OF DEATH: Month FEBRUARY Day 9 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 3 1873

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM CULBERTSON

14. MOTHER'S MAIDEN NAME: EMMA LEIDIG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: ESTER P. SEAL Address: 1618 rolling road WOODLAWN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 3-1% Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(b): Cerebral Haemorrhage — 3 days
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb-4 19 59 to Feb 7 19 59 that I last saw the deceased alive on Feb 8 19 59, and that death occurred at 8 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Baltimore DATE SIGNED: 2/9/59

PHYSICIAN'S NAME (Type): G. W. Lehan Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: FEB. 12 1959

22c. NAME OF CEMETERY OR CREMATORY: MT. ZION CEMETERY

22d. LOCATION (City, town, or county) (State): Lothian AAco. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John O Stansbury ADDRESS: 6411 Windsor Mill Road

24a. REC'D BY REGISTRAR DATE: Feb 10 59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02406

2402 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chewsville
d. STREET ADDRESS: Box 67
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First IMA Middle FAYE Last ROHRER
4. DATE OF DEATH: Month February Day 21 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 9 1907
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk in Engineering
10b. KIND OF BUSINESS OR INDUSTRY: Fairchild
11. BIRTHPLACE (State or foreign country): San Lar Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin S. Smith
14. MOTHER'S MAIDEN NAME: Carrie L. Welty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO: 217-09-9834
17. INFORMANT: Dale B. Rohrer Address: Chewsville Wash. Co Md Box 67

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis Generalized — INTERVAL BETWEEN ONSET AND DEATH: one week.
DUE TO
(b): Cancer of breast — one month.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/3/59, 19____, to 2/21/59, 19____, that I last saw the deceased alive on 2/20/59, 19____, and that death occurred at 5 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard N Welty M.D.
ADDRESS (Street, city or town, state): 136 North Potomac St., Hagerstown, Md.
DATE SIGNED: 2/22/59
PHYSICIAN'S NAME (Type): Howard N. Welty, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/23/59
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
22d. LOCATION (City, town, or county) (State): Smithsburg Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: FEB 24 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02407

2403 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Tilghmanton RFD #1
d. STREET ADDRESS: Tilghmanton RFD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Aletha Last Roulette

4. DATE OF DEATH: Month Feb. Day 10 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 5 1896
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months 3 Days 5
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Riveter
10b. KIND OF BUSINESS OR INDUSTRY: Aircraft
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Theodore Smith
14. MOTHER'S MAIDEN NAME: Minnie Davis

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO: 216 14 6289
17 INFORMANT: Mrs. Howard Swain Address: Sharpsburg Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma of the gallbladder & Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr(?)

155.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 1958, to Feb. 10, 1959, that I last saw the deceased alive on ~~2/10/59~~ 2/9/59 and that death occurred at 3:05 M, from the causes and on the date stated above.

PHYSICIAN'S SIGNATURE: W. H. Shealy M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): W. H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 12-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
22d. LOCATION (City, town, or county) (State): Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Reef ADDRESS: Williamsport, Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Evelyn L. Hurd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2404 CERTIFICATE OF DEATH

Reg. Dist. No. 2408

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MATYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 930A LANVALE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK — Middle COOKERLEY — Last SCHLEIGH

4. DATE OF DEATH: Month FEBRUARY — Day 21 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 7/22/1896

9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: BLDG. CONTRACTOR

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM L. SCHLEIGH

14 MOTHER'S MAIDEN NAME: IDA VIRGINIA ?

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service): NO

16 SOCIAL SECURITY NO: 214-09-9316

17. INFORMANT: MRS. BONNIE SCHLEIGH — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic carcinoma, left upper lobe
DUE TO: with metastasis to bone, liver, kidneys, and adrenals.
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 weeks (certain)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from January 17, 1959, to February 21 1959, that I last saw the deceased alive on February 20, 1959, and that death occurred at 9:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm T. Layman M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 2/23/59

PHYSICIAN'S NAME (Type): William T. Layman — Hagerstown — Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/24/59
22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. J. Normant Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 25 '59
24b. REGISTRAR'S SIGNATURE: [illegible] S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ■■ hours after death. ■age ■ may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and ■ should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02409

2405 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 166 North Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First TODD Middle ANTHONY Last SCHLEIGH

4. DATE OF DEATH: Month February Day 10 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 25, 1959

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months — Days 15 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert G. Schleigh

14. MOTHER'S MAIDEN NAME: Patsy Hull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Mr. Robert G. Schleigh Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: a few hrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coarctation of the aorta

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/25, 1959 to 2/10, 1959 that I last saw the deceased alive on 2/10, 1959, and that death occurred at 12:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: H. D. Bowman M.D. — ADDRESS (Street, city or town, state): 318 N. Potomac St. Hagerstown Md. — DATE SIGNED: 2/10/59

PHYSICIAN'S NAME (Type): H. D. Bowman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/11/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Kouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '59

24b. REGISTRAR'S SIGNATURE: Curtis L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

2081-2

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2'57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2406

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2410

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~City~~ Hagerstown
d. STREET ADDRESS: 118 W. Antietam Street
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Faith — Middle: Louise — Last: Shafer

4. DATE OF DEATH: Month: Feb. — Day: 7 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1925

9. AGE (In years last birthday): 33 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurent - Proprietor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Berkley County W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward J. Boward

14. MOTHER'S MAIDEN NAME: Nellie M. Starliper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO:

17. INFORMANT: Franklin E. Shafer, Jr — Address: Hagerstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun Shot (20gauge) wound into abdomen
DUE TO: Hemorrhage and shock

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot in abdomen by husband

20c. TIME OF INJURY — Month, Day, Year: Hour 9:00 a. m. — Feb. 7 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Restaurent

20f. (City or town): Hagerstown — (County): Wash — (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M D

EXAMINER'S NAME (Type): S. Robert Welle, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-7-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/10/59

22c. NAME OF CEMETERY OR CREMATORY: Spring Mill Cemetery

22d. LOCATION (City, town, or county): Berkeley Co. — (State): W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K Brown
ADDRESS: Martinsburg W.Va.

24a. REC'D BY REGISTRAR — DATE: FEB 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

47 1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2407

Reg. Dist. No. 2411

1. PLACE OF DEATH
a. COUNTY WASHINGTON
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 20 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CITY FARM FREDERICK ST.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
d. STREET ADDRESS 163 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First FRANKLIN Middle ELLSWORTH Last SHAFER JR.

4. DATE OF DEATH Month FEBRUARY Day 8 Year 19 59

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 2/28/1922

9. AGE (In years last birthday) 36 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLER

10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT CO.

11. BIRTHPLACE (State or foreign country) PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME FRANKLIN E. SHAFER SR.

14. MOTHER'S MAIDEN NAME ALICE DRILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W.#2

16. SOCIAL SECURITY NO. 214-14-6111

17. INFORMANT MRS. ALICE SHAFER Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun shot into chest in cardiac region (16 gauge shotgun)
DUE TO (b) ____
DUE TO (c) ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 176 ×

INTERVAL BETWEEN ONSET AND DEATH ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self with 16 gauge shotgun after having shot wife

20c. TIME OF INJURY Hour 8:00 p.m. Month, Day, Year 2-8-59

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In Automobile

20f. (City or town) Hagerstown (County) Wash (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE S. Robert Wells M.D.

EXAMINER'S NAME (Type) S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 2-10-59

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 2/11/59

22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. ADDRESS

22d. LOCATION (City, town, or county) HAGERSTOWN (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE W. I. Kennett Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE FEB 10 '59

24b. REGISTRAR'S SIGNATURE [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2408

CERTIFICATE OF DEATH

02412
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagers Town
c. LENGTH OF STAY IN 1b 2½ Mons.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. Hospital For Incurables

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md b. COUNTY Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill
d. STREET ADDRESS 4000 - St. Barnabas Rd SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: BERTIE Middle: CECIL Last: Shipman

4. DATE OF DEATH Month: Feb. Day: 23 Year: 1959

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 7-1903
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Shipman
14. MOTHER'S MAIDEN NAME: Elizabeth Wenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 578-09-2464
17. INFORMANT: Rosa hee Shipman Address: 4000 - St. Barnabas Rd. SE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Lobular pneumonia, bilateral	4 days
DUE TO (b)	Metastasis Lesion to brain stem	5 months
DUE TO (c)	Carcinoma of the Pharynx	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 4, 1958, to Feb. 23, 1959, that I last saw the deceased alive on Feb 23, 1959, and that death occurred at 9:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Evaristo R Laddizabal M.D. ADDRESS (Street, city or town, state): 1500 Pennsylvania Ave. DATE SIGNED: 2-24-59

PHYSICIAN'S NAME (Type): Evaristo R Laddizabal Hagerstown Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: Feb 26th
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bro. ADDRESS: 1661 Good Hope Rd SE Wash. 20 DC
24a. REC'D BY REGISTRAR DATE: FEB 2[illegible]
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Films 2,3 2-10-59 ef

02413

Reg. Dist. No.

2431

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown R#5
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown,Md. R#5
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	SAMUEL	NELSON	SIMPSON		Feb.	9,	1959

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	☒ NEVER MARRIED	Oct. 30, 1875	83 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer	Agriculture	Mercersburg, Penna.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Not Known	Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	Mr. F. L. Stockslager	Hagerstown, Md. R#5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic myocardial heart disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO: with myocardial failure grade IV

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year	20d. INJURY OCCURRED: While at work ☐ / Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
none 19		None	-	-	-

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-10-59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/12/59	Church Of God Cemetery	Blairs Valley (Clearspring) Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Rest Haven Funeral Chapel Inc. Hagerstown, Md.	R[illegible]-59	[illegible]

Wm. C. Frost, U-Pres.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2432 CERTIFICATE OF DEATH

Reg. Dist. No. 2415

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): MARTIN MANOR REST HOME

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 245 MILL ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle WALTER — Last SMITH
4. DATE OF DEATH: Month FEBRUARY — Day 13 — Year 19 59
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: UNKNOWN
9. AGE (In years last birthday): APP 78 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED LABORER
10b. KIND OF BUSINESS OR INDUSTRY: MOVING & STORAGE CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN O. SMITH
14. MOTHER'S MAIDEN NAME: SARAH C. WALTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 217-10-2544
17. INFORMANT: MISS CATHERINE W. EMBREY — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
410.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/4/59, 19____, to 2/13/59, 19____, that I last saw the deceased alive on 2/11/59, 19____, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. N. Weeks M D
ADDRESS (Street, city or town, state): 136 N. Potomac Street
DATE SIGNED: 2/14/59
PHYSICIAN'S NAME (Type): H. ward N. Weeks, M.D.
Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/15/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. T. Kennedy, Hagerstown, Md
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Clinton L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02415

Reg. Dist. No. 302

FOR STATE HEALTH DEPT.

2433

1. PLACE OF DEATH
a. COUNTY: ashington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 5
c. LENGTH OF STAY IN 1b: 30 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leitersburg Pike

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown R # 5
f. STREET ADDRESS: Leitersburg Pike
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLIAM; Middle W; Last SMITH

4. DATE OF DEATH: Month February; Day 3; Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: October 5 1889

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Foxville Fred Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Smith

14. MOTHER'S MAIDEN NAME: Mary Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO: None

17. INFORMANT: Etta K. Smith Address: Hagerstown Md. R # 5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Hour; a. m. p. m.; Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) (County) (State): - - -

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 2-4-59

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/6/59
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): near Foxville Fred Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: FEB 9 '59
24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2403

0241C

CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1901 Jefferson Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle WILLIAM Last SODERGREN

4. DATE OF DEATH: Month February Day 18 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1908

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Johann V. Sodergren

14. MOTHER'S MAIDEN NAME: Lucy Groot

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Margeurite Sodergren Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Nephrosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 16 mo.
446 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive vascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 30, 19 57, to Feb. 18, 19 59 that I last saw the deceased alive on Feb. 18, 19 59, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D. — ADDRESS (Street, city or town, state): 148 West Washington St. — DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): Dr. B. B. Kneisley — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/21/1959

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Souzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 '59

24b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DECEASED'S PHYSICIAN OR MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02417
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Smithsburg
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 68 S. Main Street

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): X Smithsburg,
d. STREET ADDRESS: 68 S. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jane — Middle: Foltz — Last: Spitzer

4. DATE OF DEATH: Month: Feb — Day: 13 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Jan. 10, 1916

9. AGE (In years last birthday): 43 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress Making

10b. KIND OF BUSINESS OR INDUSTRY: L'Aigalon

11. BIRTHPLACE (State or foreign country): Leitersburg, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harvey C. Albin

14. MOTHER'S MAIDEN NAME: Lucy E. Foltz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service): - 213-24-9086

17. INFORMANT: Catherine L. Delauter- Daughter — Address: Cavetown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation by hanging — INTERVAL BETWEEN ONSET AND DEATH

974 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Hanged self with rope from water pipe at her home

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: Feb 13 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Smithsburg, Wash Md

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-16-59

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 2-18-59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Garden

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

24a. REC'D BY REGISTRAR: FEB 19 '59

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2410

CERTIFICATE OF DEATH

Reg. Dist. No. 02418

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 38 East Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edgar	Lemuel	Strock	February	20	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Male	White		Jan. 27, 1888	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Retired	Hagerstown, Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Willoughby Strock	Louise Stockslager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT Address
No ----	212-14-7040	Mrs Ava M Strock 38 East Ave. Hagerstown. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	2 days
420.0 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Coronary Thrombosis	2 days
(c)	Arteriosclerotic Heart Disease	2 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I attended the deceased from Oct. ---, 1947, to Feb. 20, 1959, that I last saw the deceased alive on Feb. 19, 1959, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Clyde C. Hoffman M.D. 214 N. Potomac st. 2/20/59

PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb. 22/59	Rose Hill Cemetery	Hagerstown, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. RECD BY REGISTRAR FEB 24 59	24b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown. Md		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2435 — Reg. Dist. No. 2419

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dargan (Rural)
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dargan (Rural)
d. STREET ADDRESS: RFD # 1, Harpers Ferry, W.Va.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle HENRY — Last TAYLOR

4. DATE OF DEATH: Month February — Day 22, — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 8, 1871

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Dargan, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Francis Taylor

14. MOTHER'S MAIDEN NAME: Ellen Jane Wilders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 236-14-4580

17. INFORMANT (Relative): Mr. Donald B. Taylor
RFD # 1, Harpers Ferry, West Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Arteriosclerosis
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
450.0
INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Abdominal Tumor - type undiagnosed.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19 57, to 2/6/59, 19 59, that I last saw the deceased alive on Feb. 20, 19 59, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shealy M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 2/24/59

PHYSICIAN'S NAME (Type): Walter H. Shealy — Sharpesburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-24-59
22c. NAME OF CEMETERY OR CREMATORY: Samples Manor Cem.
22d. LOCATION (City, town, or county) (State): Samples Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Box 35 Harpers Ferry W. Va.

24a. REC'D BY REGISTRAR DATE: FEB 26 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2411

CERTIFICATE OF DEATH

02420

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washingtom — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 123 Randolph Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle FRANKLIN — Last THOMAS JR

4. DATE OF DEATH: Month Feb. — Day 6 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan.18,1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days 18 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Hagerstown,Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert F.Thomas

14. MOTHER'S MAIDEN NAME: Hazel R.Alter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Robert F.Thomas 123 Randolph Ave. — Address: Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 wks
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonitis + atelectasis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Feb, 1959, to 6 Feb, 1959, that I last saw the deceased alive on 5 Feb, 1959, and that death occurred at 4:25 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: F F Lusby — M.D. — ADDRESS (Street, city or town, state): 230 N Potomac Hagerstown Md — DATE SIGNED: 6-2-59

PHYSICIAN'S NAME (Type): F.F.Lusby

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2/8/59 — 22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery — 22d. LOCATION (City, town, or county): Hagerstown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.

24a. REC'D BY REGISTRAR — DATE FEB 9 '59

24b. REGISTRAR'S SIGNATURE

Wm. A. Hoop - C. Pres

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2412 CERTIFICATE OF DEATH

Reg. Dist. No. 3421

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN — c. LENGTH OF STAY IN 1b: ONE MONTH	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: JACKSON CONVALESCENT HOME	d. STREET ADDRESS: 526 BROWN AVENUE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: MAUDE	Middle: C.	Last: WACHTER	4. DATE OF DEATH: Month: FEBRUARY	Day: 22 — Year: 1959
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: JANUARY 17 1885	9. AGE (In years last birthday): 74 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME	11. BIRTHPLACE (State or foreign country): BOONSBORO WASH.CO.MD.	12 CITIZEN OF WHAT COUNTRY?: U.S.A.		
13 FATHER'S NAME: SAMUEL E.YOUNG	14 MOTHER'S MAIDEN NAME: ELLA B.COST				
15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 219-26-1840	17 INFORMANT: MISS EVELYN WACHTER	Address: 526 BROWN AVE. HAGERSTOWN MD.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 wks

DUE TO (b): arteriosclerosis — 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hemiplegia — 9 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 58, to Feb 22, 19 59, that I last saw the deceased alive on Feb 21, 19 59, and that death occurred at 2:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M D — ADDRESS (Street, city or town, state): 159 W. Washington St., Hagerstown, Md. — DATE SIGNED: 2/23/59

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	22b. DATE THEREOF: FEB.24 1959	22c NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY	22d LOCATION (City, town, or county) (State): BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE: John C. Bard	ADDRESS: Boonsboro Md	24a. REC'D BY REGISTRAR DATE: FEB 26 '59	24b REGISTRAR'S SIGNATURE	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

241 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02422

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA - Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Maugansville
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: W — Last: Weaver
4. DATE OF DEATH: Month: Feb. — Day: 25 — Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 7, 1889
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Grain Elevator Co.
11. BIRTHPLACE (State or foreign country): Greencastle Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin L Weaver
14. MOTHER'S MAIDEN NAME: Clara Walck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.: 214-03-7329
17. INFORMANT — Address: Mrs. Hattie Weaver- Maugansville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Acute coronary thrombosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18): None
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: None 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town) (County) (State): - - -

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-26-59

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-28-59
22c. NAME OF CEMETERY OR CREMATORY: Reiff Cemetery
22d. LOCATION (City, town, or county) (State): Cearfoss, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: A. E. Minnick — ADDRESS: Greencastle, Pa.
24a. REC'D BY REGISTRAR DATE: MAR 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Wards, Co. Med. **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

Countersigned D.M. E

S. Robert Wells, M.D. Feb 22 1959 **CERTIFICATE OF DEATH**

02423

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 1½ hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hosp.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md. b. COUNTY Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Lance)
d. STREET ADDRESS Near Middletown, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Thomas Middle Lafayette Last Winfield Jr.
4. DATE OF DEATH Month 2 Day 21 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/29/58
9. AGE (In years last birthday) 9 mos yrs
IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Lafayette Winfield, Sr.
14. MOTHER'S MAIDEN NAME Catherine Hart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Thomas Winfield Sr. Address — Mom.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Adrenal Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Acute hemorrhagic disease — 8 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) (Waterhouse-Friderichsen Syndrome)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/21, 1959, to 2/21, 1959, that I last saw the deceased alive on 2/21, 1959, and that death occurred at 5:45 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Richard A. Young M.D. ADDRESS (Street, city or town, state) 101 King Street Hagerstown, Md. DATE SIGNED 2/21/59

PHYSICIAN'S NAME (Type) Richard A. Young

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-24-1959
22c. NAME OF CEMETERY OR CREMATORY Mt Carmel U.B. Cem.
22d. LOCATION (City, town, or county) Frederick Co. (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE H. Cashell Co., ADDRESS Middletown, Md.
24a. REC'D BY REGISTRAR DATE FEB 25 '59
24b. REGISTRAR'S SIGNATURE Clinton S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2415 CERTIFICATE OF DEATH

02424 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 541 Frederick St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Truman — Middle L — Last Wolf

4. DATE OF DEATH: Month 2 — Day 28 — Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-1-1887

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY: self employed

11. BIRTHPLACE (State or foreign country): Boonsboro, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Wolf

14. MOTHER'S MAIDEN NAME: Laura Martz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-6168

17. INFORMANT: Mrs. Laura Wolf — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.

420.1

DUE TO (b): Atheromatous Cardiovascular Disease. — 2 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 28, 1959 to Feb. 28, 1959 that I last saw the deceased alive on Feb. 28, 1959, and that death occurred at 10:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D. — ADDRESS (Street, city or town, state): 119 North Potomac Street, Hagerstown, Maryland. — DATE SIGNED: 3-2-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 3-3-59

22c. NAME OF CEMETERY OR CREMATORY: Boonsboro

22d. LOCATION (City, town, or county) (State): Boonsboro, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraiss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2416 CERTIFICATE OF DEATH

Reg. Dist. No. 12425

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO
d. STREET ADDRESS: 1 NORTH MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSAN Middle J. Last YOUNKINS

4. DATE OF DEATH: Month FEBRUARY Day 25 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 18 1886

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: HOUSE WORK

11. BIRTHPLACE (State or foreign country): MIDDLETOWN FRED.CO.MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EMORY YOUNKINS

14. MOTHER'S MAIDEN NAME: EMMA RAY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217 30 7304

17. INFORMANT: MRS.MERIAM KELLEY Address: BOONSBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week.

DUE TO

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic C. V. disease — 5 Yrs.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonitis of the right lung and carcinoma of the colon

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1957, 19____, to Feb. 25, 1959, 19____, that I last saw the deceased alive on Dec. 24, 1958, and that death occurred at 10-P-M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. H. Shealy, M.D. ADDRESS (Street, city or town, state): Sharpsburg, Md. DATE SIGNED: 2/27/59

PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: FEB.28 1959

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — ADDRESS: Boonsboro Md

24a. REC'D BY REGISTRAR: DATE MAR 2 '59

24b. REGISTRAR'S SIGNATURE: Clifton L. Keene

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relo[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55